Opening Statement of the Honorable H. Morgan Griffith
Subcommittee on Oversight and Investigations
Hearing "Examining How Covered Entities Utilize The 340b Drug Pricing Program."
October 11, 2017

(As prepared for delivery)

Today, the Subcommittee is holding a hearing entitled "Examining How Covered Entities Utilize the 340B Drug Pricing Program." The 340B program was created by Congress in 1992 and mandates that drug manufacturers provide outpatient drugs to eligible entities at reduced prices in order for the manufacturers to remain eligible for reimbursements through entitlement programs such as Medicaid and Medicare.

The 340B program helps covered entities "stretch scarce federal resources" in order to reach more eligible patients and provide more comprehensive services to those patients. This is undoubtedly an important program. The dramatic growth of the program, however, coupled with a dearth of information about how it is used, has led to questions about whether the program has grown beyond Congress' original intent.

The Subcommittee on Oversight and Investigations has been looking into the 340B program for several months now. Our work began with an examination of the Health Resources and Services Administration's (HRSA) role in overseeing the 340B program. The Committee requested a sample of HRSA's audits in order to understand the interactions between HRSA and covered entities, and the thoroughness of HRSA's audits. In July, the Subcommittee held a hearing in which we heard from HRSA, GAO, and OIG on the challenges they face in overseeing the program.

As we heard in July, the number of unique participating entities nearly quadrupled between 2011 and 2016 without a proportional growth in oversight, and HRSA has struggled to keep up. However, our last hearing left many questions unanswered. Because of the lack of reporting requirements in the 340B statute, HRSA is simply unable to collect data on exactly how covered entities use the program.

Because HRSA is not able to report how covered entities use the program, the Committee wrote to a diverse group of entities in September about their use of the

program. We asked the entities to report a wide range of information, including the amount saved on drug purchases through participation in the 340B program, the level and type of charity care provided by the entities, and how patients benefit from 340B discounts.

Over the past few months, we have heard from these entities and many others. Some entities reached out to the Committee on their own, very eager to share with us the great work they are doing with the program dollars. We've heard from rural entities that started delivery services to ensure that patients in remote areas are able to receive their medications, entities that pass savings directly to their patients using a cash card program, and entities that are using their savings to combat the opioid crisis, including by examining prescribing practices and providing behavioral health services to their communities.

However, I am concerned by reports that not all participating entities have devoted the program dollars to improving patient care, providing access to vital services, or lowering prescription drug costs for patients. I've seen news accounts indicating that some covered entities spend millions on salaries and bonuses for their CEOs, and hundreds of millions on building expansions, even as charity care at those entities is on the decline. Perhaps even more concerning are some reports showing that patient costs are actually on the rise at some 340B entities.

In 2015, GAO found that 340B Disproportionate Share Hospitals "were either prescribing more drugs, or more expensive drugs" to Medicare Part B beneficiaries than their non-340B counterparts prescribed. Similarly, we have heard concerns that 340B hospitals are acquiring physician-owned oncology practices, which can result in higher treatment costs to patients within that practice.

The 340B Drug Pricing Program is vital to many covered entities, and by extension, to the patients that those entities serve. As such, it is crucial that Congress ensure that the program dollars are used in accordance with the intent of the program to stretch scarce federal resources as far as possible to better serve uninsured and underinsured patients. We must ensure there is accountability and transparency in the program.

I'm pleased that the panel we've assembled today includes three Disproportionate Share Hospitals that serve both urban and rural populations, one Federally Qualified Health Center, and one Ryan White Center. Each of these entities serve a different patient population, and offer services that are of particular importance to their communities.

I thank these witnesses for their cooperation in producing data to this Committee about their use of the 340B program and their willingness to appear before us today. I look forward to hearing more about the ways in which they benefit, and more importantly, how their patients benefit, from their participation in the 340B Program.